DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 7463 (Rev. 02/06)

STATE OF WISCONSIN
Adm. Code Chapters 110, 111, 112, 113
(608) 266-1568

EMS PROVIDER APPLICATION AND OPERATIONAL PLAN

Completion of this form is mandatory for licensure as an EMS provider. Updating and maintaining a current operational plan with the Department of Health and Family Services (DHFS) is required under Wisconsin Administrative Rule Chapters HFS 110, 111, 112 and 113 and s. 146.50 and 146.55, Wis. Statutes. Failure to complete, submit and obtain approval of an EMS Operational Plan may result in denial, revocation or suspension of an EMS provider license or other disciplinary action as allowed by law.

The following apply to EMS service providers per Wisconsin Administrative Codes. Before operating an EMS service, a county, city, town, village, prospective or licensed EMS service provider, hospital or any combination of these shall first submit to the DHFS an operational plan for DHFS review and approval. DHFS approval of the plan shall be a prerequisite to initiation of EMS service provision. Once an operational plan is approved, any modifications must be submitted to the DHFS **and approved** in writing prior to implementation. Once approved by DHFS, an operational plan becomes the legal description under which an EMS provider must function. No changes may be made without prior written approval of the EMS Section.

While some operational plan requirements are standard, some vary with the level of service being provided. Specific operational plan requirements for each level are listed as parts A, B, C, D and E of this application form. Complete the application and operational plan form and continue with your plan by identifying the level of care your service will offer and responding to the plan components for that level. In completing the application, attach additional sheets as necessary. **Both form DPH7463 (EMS Provider Application and Operational Plan) and the operational plan component outline for your level of service (DPH7463 part A, B, C, D or E) are required as part of the EMS Service Operational Plan.**

RETURN COMPLETED PLAN IN PRINT FORM TO THE APPROPRIATE EMS PROGRAM COORDINATOR AT:

Division of Public Health
Bureau of Local Health Support and Emergency Medical Services
PO Box 2659
Madison, WI 53701-2659

This plan is a (check one):

☐ New ☐ Change of Service License Level ☐ Change of Ownership ☐ Special Event Plan ☐ Seasonal Plan

☐ Revised Plan – Attach a document describing change and complete only that section applicable to the change.

Contact Person (submitting plan)	Telephone No.	E-mail Address

EMS PROVIDER

EMS Provider Information

Provider Legal Name	Provider License No.	FEIN

Address (where records are kept)

City	State	Zip code	County
	WI		

Day (Office) Telephone No.	Other Telephone No.	E-mail Address

Mailing Address (If different than above)

City	State	ZIP Code	County
	WI		

DEA number if applicable	CLIA waiver number	CLIA waiver expiration date

Service License Level (Check all that apply)

☐ Medical First Responder ☐ EMT Basic ☐ Intermediate Technician (formerly IV-Tech and Provisional Intermediate)

☐ EMT Intermediate ☐ EMT Paramedic

Type of Ownership (Check all that apply)

☐ Municipality Owned ☐ Private Non-Profit * ☐ Private For-Profit** ☐ Tribal Ownership

***Private Non-Profit – Submit A Copy Of Certificate Of Incorporation And A Copy Of Contract For Service**
****** **Private For Profit – Submit A Copy Of Contract For Service**

Primary Service Area Information (PSA)

List the city, townships or villages you provide primary response.

Attach a map that represents your PSA.

Station Locations

Station Identifier	Street Address	City	Zip

Insurance Information

Professional and or Medical Liability Insurance Provider Name	Policy No.	Expiration Date

Address

City	State	Zip Code	County

Agent Name

Business Telephone No.	E-mail Address

Attach a copy of current certificate of insurance.

PROVIDER ASSOCIATE INFORMATION

Owner Information

Owner Name

Mailing Address

City	State	ZIP code	County

Daytime Telephone No.	Other Telephone No.	E-mail Address

Service Director/Co-Service Director (Note this individual is the 24 hour/ 7 day contact)

Service Director, Co-Service Director or Chief Operating Officer Name	License No.

Mailing Address

City	State	ZIP code	County

Daytime Telephone No.	Other Telephone No.	E-mail Address

Service Director/Co-Service Director (Note this individual is the 24 hour/ 7 day contact)

Service Director, Co-Service Director or Chief Operating Officer Name	License No.
Mailing Address	

City	State	ZIP code	County
Daytime Telephone No.	Other Telephone No.	E-mail Address	

Medical Director

Medical Director Name	WI License Number
Mailing Address	

City	State	ZIP code	County
Daytime Telephone No.	Other Telephone No.	E-mail Address	

Attach a copy of the medical director's résumé or curriculum vitae.

Training Officer

Training Officer Name

Address

City	State	ZIP Code	County
Daytime Telephone No.	Other Telephone No.	E-mail Address	

Infection Control Contact Information

Infection Control Contact Name

Mailing address

City	State	ZIP code	County
Daytime Telephone No.	Other Telephone No.	E-mail Address	

Quality Assurance/Improvement Officer

QA or CQI Coordinator Name

Address

City	State	ZIP Code	County
Daytime Telephone No.	Other Telephone No.	E-mail Address	

Medical Control Hospital No. 1

Medical Control Hospital Name

Address

City	State	ZIP code	County
	WI		

Name of Contact Person

Daytime Telephone No.	Other Telephone No.	E-mail Address

Medical Control Hospital No. 2

Medical Control Hospital Name

Address

City	State	ZIP code	County
	WI		

Name of Contact Person

Daytime Telephone No.	Other Telephone No.	E-mail Address

STAFFING

staffing information (List licensed individuals who take the place of licensed EMS personnel to staff your service.)

RN/PA/MD Name	License No.	Address	City	State	Zip Code	CPR Expiration

staffing information (List licensed individuals who are non-EMS licensed drivers for your service.)

Driver Name	WI DL No.	Address	City	State	Zip Code	CPR Expiration

AFFILIATES (For Ambulance Service Providers)

Interface With Medical First Responder Groups

Do you have written agreements with Medical First Responder agencies? ☐ Yes ☐ No

Name	Name

AFFILIATES (For Medical First Responder Services)

Interface With Ambulance Service Providers

Do you have written agreement with ambulance service providers? ☐ Yes ☐ No

Name	Name

Mutual Aid Agreements (written backup agreements, mutual aid, ALS intercept, tiered response)

Name	Describe relationship

TRANSPORTATION

List All Vehicles Used by this Service

Local Unit No.	WI License Plate No.	VIN	Year/Make	Model	Conversion Mfg.	Vehicle type	Date last DOT Inspection

SIGNATURE PAGE TO ACCOMPANY FORM DPH7463

Name of EMS Provider | **Provider License Number**

OWNER/OPERATOR CERTIFICATION

1. I certify that the information submitted on form DPH 7463 is true and complete to the best of my knowledge. I further certify that the named EMS service will operate in conformance with s. 146.50 and s. 146.55, Wisconsin Statutes and Chapters 110, 111, 112 and/or 113 Wisconsin Administrative Code.
2. The EMS service will comply with the specifications and standards of the Wisconsin statewide emergency medical services communications system.
3. The EMS service will use the Department's run report form or a copy of an alternative report form will be provided to the Department for review and approval prior to its use. All runs will be documented on this ambulance report form and all forms will be kept and distributed in compliance with Wisconsin Statutes and Administrative Codes pertaining to patient medical records.

SIGNATURE - Owner | Date Signed

*** SERVICE DIRECTOR CERTIFICATION**

1. I certify that the information submitted on form DPH 7463 is true and complete to the best of my knowledge. I further certify that the named EMS service will operate in conformance with s. 146.50 and s. 146.55, Wisconsin Statutes and Chapters 110, 111, 112 and/or 113 Wisconsin Administrative Code.
2. The EMS service will comply with the specifications and standards of the Wisconsin statewide emergency medical services communications system.
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SIGNATURE - Director | Date Signed

*** MEDICAL DIRECTOR CERTIFICATION**

I certify that I am willing to participate in the above named EMS services' program and fulfill the responsibilities of medical director as described in this plan and to adhere to the requirements of Chapters 110, 111, 112 and/or 113, Wisconsin Administrative Code. Additionally, I certify that the attached medical protocols for this EMS service provider have been reviewed and approved by me.

SIGNATURE - Medical Director | Date Signed

QUALITY ASSURANCE CERTIFICATION

I certify that the EMS service is willing to participate in a data collection program, collect EMS data and to submit that data to the Department as requested.

SIGNATURE - Quality Assurance Representative | Date Signed

*** TRAINING CENTER CERTIFICATION**

I certify that this EMS Training Center is willing to participate in the above named EMS services' program and fulfill the responsibilities and requirements as described in this plan and to adhere to the requirements of Chapters 110, 111, 112 and/or 113, Wisconsin Administrative Code.

SIGNATURE - Training Center Representative | Date Signed

Name of Ambulance Service Provider | **Provider License Number**

MEDICAL CONTROL HOSPITAL CERTIFICATION

I certify that this hospital is willing to participate in the above named EMS services' program, providing on-line medical direction by a Wisconsin licensed physician 24 hours/7 days per week. Additionally, I certify that the facility will fulfill the responsibilities of medical control facility as described in this plan and adhere to the requirements of Chapters 110, 111, 112 and/or 113, Wisconsin Administrative Code.

SIGNATURE - Medical Control Hospital Representative | Date Signed

MEDICAL CONTROL HOSPITAL CERTIFICATION

I certify that this hospital is willing to participate in the above named EMS services' program, providing on-line medical direction by a Wisconsin licensed physician 24 hours/7 days per week. Additionally, I certify that the facility will fulfill the responsibilities of medical control facility as described in this plan and adhere to the requirements of Chapters 110, 111, 112 and/or 113, Wisconsin Administrative Code.

SIGNATURE - Medical Control Hospital Representative | Date Signed

RECEIVING HOSPITAL CERTIFICATION

I certify that this hospital is willing to participate in the above named ambulance services' program and fulfill the responsibilities of receiving hospital facility as described in this plan and to adhere to the requirements of Chapters 110, 111 and/or 112, Wisconsin Administrative Code.

SIGNATURE - Receiving Hospital Representative | Date Signed

RECEIVING HOSPITAL CERTIFICATION

I certify that this hospital is willing to participate in the above named ambulance services' program and fulfill the responsibilities of receiving hospital facility as described in this plan and to adhere to the requirements of Chapters 110, 111 and/or 112, Wisconsin Administrative Code.

SIGNATURE - Receiving Hospital Representative | Date Signed

*** AFFILIATED AMBULANCE SERVICE CERTIFICATION**

I certify that the above named Medical First Responder group is part of our tiered response.

SIGNATURE - Ambulance Service Director | Date Signed

*** AFFILIATED AMBULANCE SERVICE CERTIFICATION**

I certify that the above named Medical First Responder group is part of our tiered response.

SIGNATURE - Ambulance Service Director | Date Signed

*Identifies signatures required for Medical First Responder services.